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**NEGOTIATED RULEMAKING MEETING
 DEPARTMENT OF HEALTH AND WELFARE
 16.03.10 – MEDICAID ENHANCED PLAN BENEFITS
 DOCKET NO. 16-0310-1704**

TUESDAY, DECEMBER 19, 2017	
* Live Meeting * 1:00 p.m. to 4:00 p.m. (Mountain Local Time)	* Via Teleconference Call-In* 1:00 p.m. to 4:00 p.m. (Mountain Local Time)
3232 Elder Street Conf. Room D-East & D-West Boise, ID 83705	Toll Free: 1-877-820-7831 Participant Code: 301388

Facilitator

Karen Westbrook, Alternative Care Coordinator for Adult Developmental Disability Services, Division of Medicaid,
 Department of Health and Welfare

Purpose of the Meeting

The purpose of this meeting is to provide an opportunity for interested stakeholders to discuss and make recommendations for revisions to the Idaho Administrative Code regarding provider reimbursement rate reviews, cost survey requirements, and rate setting methodologies for home and community-based service (HCBS) providers, HCBS service coordinators, personal care service providers and therapy providers.

Agenda

<ul style="list-style-type: none"> • Welcome
<ul style="list-style-type: none"> • Review and Discussion of Draft Rule Revisions and Provider Comments
<ul style="list-style-type: none"> • Next Steps <ul style="list-style-type: none"> ○ Initial Comment Period ○ Department Revisions ○ Comment Period for Revised Draft ○ Next Negotiated Rulemaking Session
<ul style="list-style-type: none"> • Adjourn

All written comments on the negotiated rules must be received on or before January 19, 2018:

- *Mail Comments To:* Medicaid Central Office, Idaho Department of Health and Welfare, PO Box 83720, Boise, ID 83720-0036
Attn: Karen Westbrook
- *Hand Deliver Comments During Regular Business Hours (M-F from 8AM to 5PM, except holidays) To:*
Medicaid Central Office, Idaho Department of Health and Welfare, 3232 Elder Street, Boise, ID 83705
Attn: Karen Westbrook
- *Send Email Comments To:* HCBSWaivers@dhw.idaho.gov
- *Send Fax Comments To:* 1-208-332-7286

**IDAPA 16
TITLE 03
CHAPTER 10**

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.

The Department will ~~evaluate-review~~ provider reimbursement rates ~~that comply to ensure compliance~~ with 42 U.S.C. 1396a(a)(30)(A). This ~~evaluation-review~~ will ~~assure-ensure~~ payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. (4-4-13)()

01. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys ~~when an access or quality indicator reflects a potential access or quality issue described in Subsections 037.02 and 037.03 of this rule as follows:~~ (4-4-13)()

02. a. Access. ~~The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues.~~ (4-4-13)

~~a. Compare the change in total number of provider locations for service type to the change in eligible participants; or (4-4-13) ()~~

~~b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type.(4-4-13)~~

~~When substantiated participant complaints and critical incidents related to a lack of qualified providers indicate an emerging access issue for a service type.~~

03. b. Quality. ~~The Department will review quality reports required by each program used to monitor for patterns indicating an emerging quality issue.~~ (4-4-13)

~~i. When quality reports required by each program indicate an emerging quality issue for a service type. ()~~

~~ii. When substantiated participant complaints and critical incidents related to abuse, neglect, and exploitation by providers indicate an emerging quality issue for a service type. ()~~

c. Wages and Employer-Related Expenditures. ()

~~i. When Federal minimum wage requirements and/or Idaho state minimum wage requirements in effect as of [the first day of each state fiscal year] increase (or decrease) by [X%] or more over (or under) the same wage requirement from the previous year; ()~~

Commented [WK1]: Providers recommended:
• triggers that would reflect material changes in providers' operating costs and address high turn-over rates.
• Annual adjustments -- the proposed language would require an annual review

ii. When wage estimates for the comparable occupation title for direct care staff identified using the most recent "State Occupational Employment and Wage Estimates – Idaho" published as of [the first day of each state fiscal year] increases (or decreases) by [X%] or more over (or under) the same wage estimate from the previous year: _____ ()

iii. When employer-related expenditures percentage identified using the most recent Bureau of Labor and Statistics' "Employer Costs for Employee Compensation for the Mountain West Division," and the Internal Revenue Service's employer costs for the social security benefit and the Medicare benefit published as of [the first day of each state fiscal year] increases (or decreases) by [X%] or more over (or under) the same employer-related expenditures percentage from the previous year: _____ ()

d. **Standard Review Period.** Not less than once every [X years] for each service type, and in accordance with the schedule established by the Department. _____ ()

04. **Cost Survey.** The Department will survey providers to identify the actual cost of providing services. _____ ()

a. **Participation.** The Department will survey one hundred percent (100%) of providers. Providers that refuse or fail to respond to the periodic state surveys may be disenrolled as a Medicaid provider. (4-4-13) ()

b. **Customization.** The Department will conduct cost surveys customized for each of the services defined in Section 038 of these rules. (4-4-13) ()

c. **Independent Cost Survey Consultant.** _____ ()

d. **Cost Survey Training for Providers.** _____ ()

e. **Cost Survey Validation.** _____ ()

f. **No Obligation.** The Department is not obligated to revise reimbursement rates each time a cost survey is conducted. Conducting a cost survey does not guarantee a reimbursement rate increase. Any increases are subject to approval by the State Legislature. _____ ()

05. **Reimbursement Methodology.** The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. Reimbursement rates will be based on surveyed data of providers' actual costs and derived using a combination of four cost components – direct care staff wages, employer related expenditures, program related costs, and indirect general and administrative costs as follows: _____ ()

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. (4-4-13)

b. For employer related expenditures: (4-4-13)

Commented [WK2]: • Providers recommended modifying this provision to only require participation by a representative provider sample determined by independent consultant conducting rate survey
• But may not use all data if certain factors corrupt data

Commented [WK3]: Providers recommended consultant must be experienced with HCBS fee-for-service rate studies, with multi-state experience, and prior work approved by CMS.

Commented [WK4]: Providers recommended adequate face-to-face training and on-going consultation with independent cost survey consultant.

Commented [WK5]: • Providers recommended independent consultant validate data received against sample general ledgers.
• Are there other ways to validate data and exclude corrupt data

Commented [WK6]: Providers recommended Arizona "Brick" Method.

Commented [WK7]: Providers recommended specific definitions for what costs could be included in providers' survey responses.

Commented [WK8]: Providers recommended either:
• One BLS occupation title that aligns with the highest level of skill required and how direct service staff spend most of their time; or
• A weighted combination of BLS categories.

i. The Bureau of Labor Statistics' report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov.

(4-4-13)

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov.

(4-4-13)

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate.

(4-4-13)

06. Notice of Rate Changes. ~~The Department shall provide public notice if reimbursement rates for any service defined in Section 038 of these rules are to be established or revised.~~ ()

Commented [WK9]: Providers recommended public notice requirements around proposed rate methodology changes and rate changes, may want to consider content, publication/distribution, comment periods, public hearings, and final notices.

038. GENERAL REIMBURSEMENT: TYPES OF PARTICIPANT SERVICES.

The following types of services are reimbursed as provided in Section 037 of these rules. (4-4-13)

01. Personal Care Services. The fees for personal Care Services (PCS) described in Sections ~~300-308~~ of these rules. (4-4-13)()

02. Aged and Disabled Waiver Services. The fees for ~~personal care~~ Aged and Disabled Waiver services (~~PCSA&D Waiver Services~~) described in Sections ~~320-330~~ of these rules. (4-4-13)()

03. Children's Waiver Services. The fees for children's waiver services described in Sections ~~680-686~~ of these rules. (4-4-13)()

04. ~~Children's Developmental Disabilities Home and Community-Based State Plan Option Services.~~ The fees for ~~Children's Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 660-666 of these rules.~~ ()

05. Adults with Developmental Disabilities Waiver Services. The fees for adults with developmental disabilities waiver services described in Sections ~~700-706~~ of these rules. (4-4-13)()

06. ~~Adult Developmental Disabilities Home and Community-Based State Plan Option Services.~~ The fees for ~~Adult Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 645-657 of these rules.~~ ()

0507. Service Coordination. The fees for service coordination described in Section 720 of these rules. (4-4-13)

06. Therapy Services. The fees for physical therapy, occupational therapy, and speech-language pathology services described in Section 215 of these rules include the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the client for the use of such equipment. (4-4-13)

Commented [WK10]: Consider whether to remove.

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.

Providers are reimbursed on a fee for service basis based on a participant budget. (3-29-12)

01. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-29-12)

a. The Department notifies each participant of his set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-29-12)

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-29-12)

02. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision *and have an SIB-R Support Level of Pervasive, Extensive, or Frequent as determined by the Department-Approved Assessment Tool*. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-19-07)

b. Participant-Choice High support is for those participants who require twenty-four (24) hour per day supports and supervision as determined by the Department-Approved Assessment Tool, and who have chosen to live alone or with a participant receiving intense support. This support level requires a one-to-one staff-to-participant ratio. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the Participant-Choice high support daily rate. To qualify for this level of support, the participant's choice to live alone or with a participant receiving intense support must be documented in the person-centered plan and prior approved by the Department. ()

Commented [WK11]: Providers recommended 1:1 high supports rates.

b-c. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision *as determined by the Department-Approved Assessment Tool*. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed by

the Department and approved or denied on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. Intense supports for this type of aggressive behavior may be provided with a two-to-one staff-to-participant ratio when needed to assure the health or safety of the participant, requested in the participants' person-centered plan, and prior approved by the Department in accordance with these rules. (3-19-07) ()

iv. Chronic or acute medical conditions that are so complex or unstable that ~~one-to-one staffing is required to provide~~ frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. Intense supports for this type of chronic or acute medical conditions may be provided with two-to-one staff-to-participant ratio when needed to assure the health or safety of the participant, requested in the participants' person-centered plan, and prior approved by the Department in accordance with these rules. (3-19-07) ()

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. (7-1-16)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-16)

03. Exception Review. The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: (4-11-15)

a. Services are needed to assure the health or safety of participants and the services requested on the plan or addendum are required based on medical necessity as defined in Section 012 of these rules. (7-1-17)T

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (4-11-15)

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (4-11-15)

ii. The participant's plan of service was developed by the participant and his person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and (4-11-15)

iii. An acknowledgement signed by the participant and his legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (4-11-15)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-16)

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

03. Rates. The reimbursement rates calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided transportation. (3-19-07)

04. Minimum Allocation of Rate for Direct Care Workers. Each provider agency must ensure that its direct care staff base wage plus employer-related expenses, as identified in Section 037 of these rules, account for not less than [X %] of the agency's total annual fiscal year Medicaid reimbursements (excluding any incentive payments) for residential habilitation services. ()

a. The Department may conduct quality assurance audits in accordance with Section 515 of these rules to assure residential habilitation agencies' compliance with this minimum allocation requirement. ()

b. In addition to the allowable remedies under Section 515 of these rules, any residential habilitation agency that is out of compliance with this minimum allocation requirement will: ()

i. Forfeit reimbursements in an amount equal to the difference between (1) the amount the agency actually allocated to direct care staff base wages combined with employer-related expenses and (2) the minimum allocation requirement; and ()

ii. Be subject to civil monetary penalties assessed by the Medicaid Program Integrity Unit in accordance with 56-209h, Idaho Code. ()

06. Quality Incentives. ()

Commented [WK12]: Applicable to all providers? How will we decide?

Commented [WK13]: Providers recommended audits to ensure wages in line with base wage used to calculate reimbursement rate instead of set percentage.

Commented [WK14]: Providers recommended delaying Quality Incentives program until rate methodology agreed upon.